Research Article

How do Patients and Managers Value Gold Standard Elements in Primary Health Care

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Abstract

The study explores how Primary Health Care Team managers in Catalonia assess the gold standard criteria for excellence in Primary Health Care and whether there are differences in evaluations between the best and worst-rated centers by patients in a patient experience survey included in the Catalan Satisfaction Survey Plan (PLAENSA). The researchers used mixed methods to analyze 12 interviews done to Primary Care Team (PCT) managers. Interviews were transcribed and analyzed, yielding three themes and 12 subthemes. A Likert-type questionnaire was also used to compare results. Scores were observed between 4.8 and 3.5 regarding a constant relationship with the patient (longitudinality), and patient's experience, respectively. All managers highlight accessibility, nursing management, and administrative support as essential to patient experience. No significant differences exist in PCT's scores or gold standard element application. Disposing of good accessibility, crucial in Primary Health Care management, an administrative team, and efficiently prepared and motivated professionals, are key elements to a patient's experience in Primary Health Care. Contrary to other studies, interviewees described better accessibility in rural centers, which is likely why they are better valued by patients.

Keywords

patient experience, patient satisfaction, patient's perception of care, Primary Health Care management, healthcare services quality, rural centers, PLAENSA

Introduction

The Primary Health Care system is relevant because it ensures universal care. Quality at this first level of care is related to accessibility, longitudinality, comprehensive care, and coordination between professionals.[1]

The Catalan healthcare model was established in 1990 and integrates all public and private nonprofit healthcare resources into a network for public use.[2] The Institut Català de la Salut (ICS) is publicly managed. Integrated Health Organizations (OSI) assign economic resources depending on the number of people they take care of, considering their demographic characteristics and health necessities. In Associative-Based Entities, professionals administrate resources autonomously.

World Health Organization defines quality care as effective, efficient, integrated, equitable, safe, and patient-centered service delivery.[3] Berwick et al[4] include the patient as part of quality care and highlight their experience as one of the objectives of the Triple AIM.[5] In 2014, it evolved into the Quadruple AIM[6] to include the well-being of the professional team as a fourth vertex of healthcare quality.

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Patient-Reported Experience Measures are validated and internationally recognized instruments to measure patient experience.[7] In Catalonia, the Satisfaction Survey Plan (PLAENSA) offers patients experience results in the Observatory of the Health System of Catalonia since 2012.[8] The latest PLAENSA report, covering 2018 to 2022. It offers data on different healthcare devices such as Primary Health Care (PC).[9]

Varela et al[10] defined 22 Gold Standard PC criteria for excellence. Our work's objective is to explore how the Primary Care Team (PCT) managers assess the Gold Standard criteria and the variables' weight and whether there are differences in the management between the best and worst-rated centers in the PLAENSA surveys.

Materials and Methodology

The PLAENSA surveys from 2015 to 2022 in Primary Health Care and the Gold Standard PC indicators described by Varela et al were used as references.

A mixed methods technique (qualitative and quantitative)[11] was used to mitigate the study limitations,[12] understand the information from a multidimensional prism, and maintain reliability and validity.[13,14]

Qualitative design with phenomenological approach and nonprobabilistic[15] intentional sampling to identify 21 centers worst and best scoring in the PLAENSA surveys during the 2015 to 2022 editions. Twelve managers of mixed genders, from rural and urban centers, with medical and nursing backgrounds were interviewed. All with experience in management and direction of the three management models in Catalonia. They were identified with alphanumeric codes. Eight professionals who did not respond to the invitation were excluded (Table 1).

The interview guide (Supplemental annex 1) was developed based on published literature,[16] the Gold Standard elements, and the authors' experience. The 12 interviews, which averaged 35 min, were transcribed verbatim. Braun and Clarke's[17] six-step inductive approach was used for thematic analysis. Thirty-eight codes were identified and synthesized into three themes and 12 subthemes. Data were collected and analyzed until information saturation.[18]

The quantitative design used a Likert-type questionnaire of 31 questions adapted from Gold Standard indicators (Supplemental annex 2). Participants were asked to rate the degree of agreement with each Gold Standard indicator on a scale of 1 to 5. The coincidence of the results obtained from the two approaches facilitated comparing the qualitative and quantitative results and allowed the consistency between two kinds of data to be verified.[19] The qualitative and quantitative fieldwork was carried out from June 2023 to February 2024.

Ethical Considerations

Participants were informed about the study's purpose and the possibility of withdrawing at any time, while data confidentiality was assured. Informed consent was obtained and recorded verbally. The interviews were recorded, and the data were stored according to the General Data Protection Regulation (GDPR). Any identifying data inadvertently captured was deleted.

Quantitative Results

Table 2 summarizes the managers' scores for each question (graphs added in Supplemental annex 3). The best scores with a high degree of coincidence were professional engagement, PCT integration, longitudinality, availability of professionals who act as consultors (clinical reference), teamwork, right care, agenda availability, and adequate treatment areas.

Table 1. Profile of Interviewed Managers: Personal Characteristics (i.e., Gender, Profession, Management Experience), Center (Managing Entity, Rural/Urban), and PLAENSA Rating (Best/Worst).

Manager	Center	Urban/ Rural	Profession	Gender	PLAENSA rating	Management experience in (years)	Experience in current position (years)
D1	ICS	Rural	Nurse	Female	Best	23	14
D2	EBA	Urban	Doctor	Male	Best	22	22
D3	ICS	Rural	Nurse	Female	Best	18	8
D4	OSI	Rural	Doctor	Female	Best	28	8
D5	ICS	Rural	Nurse	Female	Best	12	12
D6	OSI	Urban	Doctor	Male	Worst	4	4
D7	ICS	Urban	Nurse	Female	Worst	9	6
D8	ICS	Rural	Doctor	Male	Best	0.5	0.5
D9	ICS	Rural	Doctor	Male	Best	25	25
D10	ICS	Urban	Doctor	Female	Worst	2	2
D11	OSI	Urban	Doctor	Female	Worst	10	1
D12	ICS	Urban	Doctor	Female	Worst	2	2

Abbreviations: ICS, Institut Català de la Salut; OSI, Integrated Health Organizations; EBA, Associative-Based Entities.

Table 2. Managers' Scores on the Gold Standard Dimensions.[a]

Themes and Subthemes Mean(SD), mean (SD) best, mean(SD) worst, Difference between means	Questions	Mean (DE)	Mean (DE) Best Plaensa	Meam (DE) Worst Plaensa	Variance between best-worst (mean)
Organization					
Accessibility	P1. Availability of Agendas	4.67 (0.49)	4.86 (0.38)	4.40 (0.55)	0.46
4.35(0.51)	P20. Provision for mental and sexual health, podiatry, and dentistry services	4.33 (1.23)	4.00 (1.53)	4.80 (0.45)	−0.80
4.18 (0.53)					
4.60 (0.38)	P4. Proactive scheduling	4.33 (0.79)	4.14 (0.90)	4.60 (0.55)	−0.46
−0.42	P22. Budget allocation for external complementary tests.	4.08 (0.67)	3.71 (1.25)	4.60 (0.89)	−0.89
Territorial Alliance	P11. Social Prescription	4.00 (1.28)	3.57 (1.51)	4.60 (0.55)	−1.03
4.46(0.53)	P12. Promotion of community health	4.58 (0.67)	4.43 (0.79)	4.80 (0.45)	−0.37
4.35 (0.58)	P13. Community pharmacy alliance	4.50 (0.80)	4.14 (0.90)	5.00 (-)	−0.86
4.63 (0.58)	P14. PCT integration	4.75 (0.45)	4.71 (0.49)	4.80 (0.45)	−0.09
−0.28	P17. Territorial Alliance for childcare	4.33 (1.00)	4.14 (1.07)	4.60 (0.89)	−0.46
	P16. Updated information on hospital admissions	4.58 (0.79)	4.71 (0.76)	4.40 (0.89)	0.31
	P18. Pediatric service support of the referring hospital	4.50 (0.67)	4.71 (0.49)	4.40 (0.89)	0.31
Multidisciplinary approach	P19. Multidisciplinary team in collaboration with Social Services.	4.67 (0.65)	4.71 (0.49)	4.60 (0.81)	0.11
4.67(0.65)					
0.11					
Non Face to Face Visits	P3. Protocols for non-face-to-face visits	4.00 (0.85)	3.86 (0.90)	4.20 (0.84)	−0.34
3.50(0.87)	P24. Efficient and useful video consultations	2.92 (1.16)	2.86 (0.90)	3.00 (1.58)	−0.14
3.48 (0.74)					
3.53 (1.12)	P21. Telemedicine for most common specialties	3.58 (1.31)	3.71 (1.25)	3.40 (1.52)	0.31
−0.05					
Longitudinality	P32. longitudinality value in patient's experience	4.67 (0.49)	4.86 (0.38)	4.4 (0.55)	0.46
4.67(0,49)					
0.46					
Professionals					
Value Chain	P15. Clinical sessions and training with the hospital.	4.42 (1.00)	4.57 (0.79)	4.20 (1.30)	0.37
4.25(0.72)	P23. Availability of clinical references and right care work groups	4.08 (0.49)	4,00 (0.58)	4.20 (0.84)	−0.20
4.29 (0.49)					
4.20 (1.04)					
0.09					
Labor Climate	P28. Promotion of positive leadership	4.83 (0.58)	5.0 (-)	4.60 (0.89)	0.40
4.75(0.43)	P26. Management of the right talent	4.58 (0.79)	4.57 (0.79)	4.60 (0.89)	−0.03
4.86(0.20)	P29. Professional engagement in fundamental decisions.	4.75 (0.45)	4.86 (0.38)	4.60 (0.55)	0.26
4.60(0.63)					
0.26	P27. Burnout prevention	4.83 (0.58)	5.0 (-)	4.60 (0.89)	0.40
Administrative Team	P6. Incorporation of new professional roles such as clinical assistant	4.42 (1.08)	4.29 (1.25)	4.60 (0.89)	−0.31
4.42(1.08)					
−0.31					
Nursing Team	P5. Child care by nurses.	3.92 (1.08)	4.14 (1.07)	3.60 (1.14)	0.54
4.17(0.72)	P2. Nurse Management demand	4.42 (0.67)	4.43 (0.53)	4.40 (0.89)	0.03
4.29(0.76)					
4.00(0.79)					
0.29					
Patient-centered care					
Patient's experience	P10. Implement cocreation dynamics with patients	3.50 (0.9)	3.43 (0.79)	3.60 (1.14)	−0.17
3.50(0.90)					
−0.17					

Table 2. (continued)

Themes and Subthemes Mean(SD), mean (SD) best, mean(SD) worst, Difference between means	Questions	Mean (DE)	Mean (DE) Best Plaensa	Meam (DE) Worst Plaensa	Variance between best-worst (mean)
Comments and recommedations **4.12(0.38)** **4.21(0.39)** **4.00(0.35)** **0.21**	P9. Consider patient's opinion on organizational matters.	3.58 (1.08)	3.71 (1.11)	3.40 (1.14)	0.31
	P25. Availability of treatment consultation areas.	4.67 (0.49)	4.71(0.49)	4.60 (0.55)	0.11
Biopsychosocial attention **3.79(1.05)** **3.50(1.15)** **4.20(0.84)** **−0.70**	P8. Specific preparation of nursing staff for SDM	3.92 (1.08)	3.71 (1.25)	4.20 (0.84)	−0.49
	P7. Specific preparation of medical personnel for SDM	3.67 (1.07)	3.29 (1.11)	4.20 (0.84)	−0.91
Satisfaction **4.12(0.91)** **4.07(1.06)** **4.20(0.76)** **−0.13**	P30. Is patient's satisfaction an indicator of quality?	4.33 (1.07)	3.86 (1.46)	4.00 (1.00)	−0.14
	P31. The importance of Plaensa.	3.92 (1.24)	4.29 (1.25)	4.40 (0.89)	0.11

[a]Comparison between the scores of the primary care managers of the centers with the best and worst PLAENSA values.

Other areas that showed good scores but with lesser agreement included positive leadership promotion, burnout prevention, multidisciplinary teams with social services, talent management, updated information on hospital admissions, and community health promotion.

There is a third group of good evaluations but with profound disagreements, such as the relationship with community pharmacies, satisfaction as an indicator of quality, administrative support, clinical sessions between professionals of different levels of care, medical support services, and pediatric care.

Finally, there are criteria with the worst evaluation and most significant disagreement, such as the managers' importance to the PLAENSA results, pediatric and mental health care by the nursing team, preparation of the medical team in shared decision-making (SDM), use of telemedicine, patient participation in organizational matters, cocreation dynamics with patients, and video consultations.

Upon categorizing the questions, scores of decreasing importance were observed for the work environment, longitudinality, multidisciplinary care, local collaborative strategies (territory alliances), accessibility and administrative team, interconnected activities that add value to patient care (value chains), nursing team, complaints and suggestions, patient satisfaction, biological care, psychosocial, and patient experience, ranging between values of 4.8 and 3.5.

Table 2 compares the scores of the Primary Health Care managers of the centers with the best and worst PLAENSA values. Some considerations stood out when average scores were reviewed on the different subtopics and questions between these two groups of managers. The most critical differences in average scores favor the centers with the worst PLAENSA values. They highlight the better assessment of prescription of activities and community services to improve the physical, mental, and social well-being of patients (social prescription), SDM, budget allocation to realize medical tests, alliances with community pharmacies, and complementary health services such as mental health, sexual health, podiatry, and dentistry.

When analyzing the subthemes, emphasis on the orientation toward biopsychosocial assistance shows a higher accessibility rating in the centers than the others, with no substantial differences in other subtopics. The highest score of the best-rated centers in PLAENSA was given to improving pediatric care (community, nursing, and hospital) concerning longitudinality and the "gaps" (free time to be scheduled) in the agendas.

The worst and best centers rated by PLAENSA scored the same regarding the importance of the patient experience as an element of health quality or nursing demand management.

Qualitative Results

Out of the 12 managers, 3 nurses and 4 doctors with an average of 20 years of management experience got the best scores. Six manage rural centers and 1 manages a rural center. Five are managed by ICS and 2 by OSI and EVA. Alternatively, 1 nurse and 4 doctors, with an average of 5 years of management experience, manage the 5 worst scored centers, 3 managed by ICS and 2 managed by OSI (Table 1).

Table 3. Verbatim of the 12 Interviewed Directive Grouped by Theme, Subtheme and Characteristics of the Primary Care Team Best and Worst Valued.

Theme	Subtheme	Description	Characteristics and verbatims of best valued	Characteristics and verbatims of worst valued
Organization	Accessibility	Ease of access to timely, affordable and quality care.	• Proactive chronic patients programming: D5 "…. we try to be proactive and organize a bit our agendas" • Health administrators speeds up the attention to demand: D1 "…. the speed up of the demand is very given to us because the management is done at the counter" • Nursing Demand Management (NDM): D2 "…. we do not have any results yet, because we are just starting to implement it now"	• Proactive programming: D10 "…being more proactive, we improve a lot the quality of the approach, because then they (the professionals) will have much more time for a patient" • Competent health administrators: D7 "…. disposing of a competent and involved team of health administrators that knows their team and are able to detect the needs of the person who they attend" • Nursing Demand Management (NDM): D6 "…we have realized that in 98% of the cases, nursery returns the patient to the doctor, which means the visit has doubled"
	Territorial alliances	Continuous, comprehensive and permanent health care is provided to a specific population within a specific territory to promote community health to	• Very Little coordination with Community Social Work: D1 "…we have trouble with city councils socials services. We often doble activity" • The population has no knowledge of the relations with the territory: D4 "…I do not know how far the people are conscious about all of this"	• Troubled relations with the community: D7 "… Social entities of the city council have trouble sharing recourses" • Little impact on the patient: (D11, D6) "…I do not know if in this moments it has any impact n the patient's satisfaction"
	Multidisciplinary approach	Professionals comprising different disciplines provide a comprehensive approach to respond to the patients' needs.	• Trust between professionals is key: D1 "…there needs to be trust between the professionals that are working" • Impact in patients' safety: D8 "…it improves patients' safety because, when we teamwork, it also improves the overall quality of care"	• The professionals' formation is more important than the multidisciplinary approach: D12 "…I think it is important that the patient notices the quality of the team" • Medicocentric view of the patients: D7 "…we are doing an effort to transform the medicocentric system into a multidisciplinary one, however, sometimes, it is not always perceived as the best care"
	Longitudinality	Stable relationship maintained by professionals accompanying their patients over time.	• Clinical management is more than patient's satisfaction: D8 "… longitudinality is valued as an indicator of patients' satisfaction, nevertheless, the importance of longitudinality is its clinical relevance, since it is what gives us the greatest reduction in morbidity and mortality in patients" • In all professional roles: D4 "…it is important even for the administrative"	• Included in the professional's economic remuneration: D6 "…. we have this in this year's objectives: that 70% of the visits must be made by your family doctor" • In assistance processes: D7 "…the person who accompanies the patient in the diagnostic process with that wound which has become chronic, is always the same professional" • Applied to the whole team: D11 "…the patient must have their reference team, not just their doctor"

(continued)

Table 3. (continued)

Theme	Subtheme	Description	Characteristics and verbatims of best valued	Characteristics and verbatims of worst valued
Professionals	Value chain	Management tool which seeks to improve clinical results, beyond simple coordination in a multidisciplinary team to an extensive vision of the entire process.	• Unawareness of the concept of value chains: D8 "…In our center as such, I am not aware that there are right care working groups. Maybe at the management level or the SAP level as centers, they may have" • Developing the clinical references team: D3 "…Now, a new clinical reference team has been created"	• Unawareness of the concept of value chains: D12 "…Value chain?…as in what?, for example?" • There is no impact in patient's experience: D11 "…I am not certain whether the patient is fully aware of it or not"
	Labor climate	Set of routine activities that influence workers' satisfaction in their work environment.	• The key to patient's satisfaction: (D3, D9). D9 "…Satisfying the expectations of the external customer must go through the previous step of satisfying those of the internal customer, which is the staff"	• Difficulties due to negative dynamics with professionals: D10 "The administrative staff has a very deep-rooted schedule and to say 'this is what you have to do' is difficult to aply because there is laziness" • The professionals do not feel supported by the patients in their revindications D6 "…instead of giving us support, the patients said: 'we already pay you enough and on top of it, you complain'"
	Healthcare administrative team	Professionals who have administrative-health functions are collaborative in both the care and guidance of the people.	• It is important to manage the administrative staff at the registration to direct the request to the right area: D5 "They are the ones to say: 'I will write this down for the doctor' or 'I will write this down for the nurse'. Their training and their conviction are fundamental" • Role models for the population: D3 "…They can respond to a burocratic demand perfectly and this helps to achieve greater user satisfaction"	• Their role is very important to organize the demand: D12 "…at the counter, having health administrators ready to organize the demand is a top priority"
	Nursing team	A group of professionals assigned to attend to people with mild acute illnesses, guided by a common protocol within their area of competence. They can be independent in the patient's care and resolutions of mild acute problems.	• Needed in infant care: D2 "…the collaboration between the nurse and the family doctor are more than convenient and necessary in infant care" • Infant care provided by the nurse is not satisfactory for the patient: D4: "…I believe that, for the satisfaction of the user, it is not a good idea. However, we think that we can carry it out"	• Importance of the role of the nursing team: D12 "…the importance of the nurses' competence in pediatrics. However, not only to pediatrics, but to adults as well"
Patient-centered care	Patient's experience	A set of perceptions by patients on the healthcare they received from their first encounter until the end of their treatment,	• Experience does not equal satisfaction: D3 "…I believe that patients are satisfied as long as you can respond to the demand that they ask you" • An administrative team is basic for a good patient's experience D9 "… to have a healthcare administrative team who know the protocols, are	• Commodification of care: D10 "…Patients have been accustomed to a 'I want you to do it for me because I pay you to' mentality …Changing that mentality is hard" • Shared clinical and organization decision making with patients improve their experience: D12 "…I

(continued)

Table 3. (continued)

Theme	Subtheme	Description	Characteristics and verbatims of best valued	Characteristics and verbatims of worst valued
		which is based on safety, quality and patient satisfaction	empathetic and motivated is a basic guideline in user's satisfaction"	think that if we make them partake into how we are organized, they will thank it and increase their confidence in us"
	Biopsychosocial care	An approach which recognizes the interplay between biological, psychological and social aspects of human experience.	• Importance of getting to know the patient and the environment in which they live: D4" …when you come into a user's home, you get to know their family and social environment… it is way more different than following someone you do not know at all."	*There are no references in this group of directives to biopsychosocial care.*
	Complaints and suggestions	Complaints are exemplified by dissatisfaction of patient's unmet needs. Suggestions are for improvement as proposed by patients.	• Complaints and suggestions are made depending on the expectations of the patient: D9 "…. high expectations that are given as a result of an inappropriate understanding of publicity lead to in a big part of complaints made by patients with idiosyncrasy of exigence and poorly understood care" • Complaints are considered misunderstandings which are often managed with a certain partiality in favor of the professional: D2 "…if there is any complaint, firstly I speak with my coworker …I always recognize my bias toward my coworkers because these complaints are often caused by misunderstandings"	• Tools for improvement: D10 "….When i entered into Management, we had 133 complaints…. we took into consideration the problems and opinions of the patients to improve organization queries"

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Below is a comprehensive summary of the results based on 3 themes and 12 subthemes (Table 3).

Theme 1: Organization. Five subtopics were highlighted:

Accessibility: Quick access to tests improves the user's experience, while a lack of maternal and childcare services worsens it. Responsible use of health services by patients is valued. The limited availability of professionals and budget allocation was singled out as a problem in rural areas. Teleconsulting visits can improve accessibility in these areas. Managing care requests remains a problem for some professionals ("…our problem is always with specific professionals who have much tendency to reprogram patients" (D4)).

Territory alliances: They are essential but complicated and minimally improve the patient experience. City councils sometimes allocate resources poorly. To avoid this situation, more collaboration between social services and Primary Health Care is suggested ("…It is difficult for the social entities of the City Council to share resources" (D7)). Social prescribing pilot tests are successful but hampered by rural areas' lack of facilities.

Multidisciplinary care: It is considered essential for quality care, generates trust, and solves problems efficiently. However, the patient's expectation that care will always be medical can limit the acceptance of other professionals ("…An effort is being made to move from a medico-centric model to a multidisciplinary model, although sometimes, it is not in the expectations of patients." (D7)).

Longitudinality: Some centers have incorporated it into economic compensation based on objectives achievement (Management by Objectives), which requires adequate provision of professionals to cover sick leaves and vacations. In some cases, it occurs in a specific clinical process. "…we understand it by processes, that is, the same person who accompanies the patient in that diagnostic process" (D7).

Non-face-to-face visits: Doctors can ask for a specialist's colleague's opinion and do consults through digital platforms (e-consultations), but not video consultations, which are recommended for some patients, although not for the elderly. In rural areas, video consultations are not necessary, due to good accessibility and lack of demand. They support telephone visits but warn about their excessive use, which could affect the quality of care. "…the convenience of telephone visits has the danger of excessive use" (D9).

Theme 2: Professionals. Four subtopics were considered:

Value chains: Managers are unfamiliar with this tool, which is perceived for high management. They usually have a referring doctor for the most common diseases and specific treatments, such as wounds, but they do not do activities jointly to add value to the patient. "…Maybe at the management level or the SAP level as centers they may have" (D8).

Nursing team: Some centers are developing nursing demand management, valued positively but seen as unresolved and duplicating visits. The nursing team is seen as having little capacity but is essential for proactive visits and as case managers. "…in 98% of cases, the nurse returns the patient to the doctor" (D6).

Health administrative team: Valued for its agenda management and efficient care. In some cases, it is considered part of the healthcare team. "…they respond to administrative requests that can be resolved at the counter" (D1).

Work environment: The work environment influences staff satisfaction and the quality of patient care. In rural settings, it can affect professional retention and team cohesion. "…We always have a full staff of doctors, which impacts user care" (D8).

Theme 3: Patient-centered care. Three subtopics were detected:

Patient experience: Meeting patient needs and responding to their demands improves their experience. "…patients feel satisfied as long as you can respond to the demand they ask of you" (D3).

Complaints and suggestions: Managers give them relative importance and sometimes they relate them to the inappropriate use of services; however, they see them as a tool for improvement. "…we collected many problems from patients' opinions and improved many of the organizational things" (D10).

Biopsychosocial care: Knowing the patient and their environment is essential for quality care. Young patients require a different approach than older patients. "…in the end, they end up telling you what you say" (D11).

Discussion

In our study, managers from the worst-scored centers value patient feedback as an asset to implement improvements. However, they highlight that patient expectations sometimes don't align with quality care, and they point out that patients need more skills to participate in organizational decisions or to partake in improvement actions.

Consequently, in line with other published studies,[20] managers have a somewhat contradictory opinion of patients: They consider them competent to evaluate the quality of care but biased by unmet expectations that have little or nothing to do with care quality.[21] This weakens the potential for changes to improve in response to patient feedback.[22]

The results of our study coincide with others wherein it is concluded that well-organized multidisciplinary teams improve the experience of patients with increasingly complex needs.[23] At the same time, they can improve accessibility by delegating certain medical team activities to other team members.[24] However, patients' medicocentric vision and their desire to be treated exclusively by these professionals represent a handicap in its implementation, which is agreed on by all interviewees. This finding complements the barriers described in the literature for multidisciplinary care.[25]

Patient demand management by the nursing team was initiated in 2009 by the ICS,[26] considering that part of the

activity carried out by doctors could be delegated to the nurse. As in other studies, ours identified barriers in some of the worst-scored centers to have effective and efficient patient demand management by the nursing team, such as the lack of empowerment, knowledge, and skills, as well as the need for more protocolization of interventions.[27] Like other studies, telephonic evaluation of patient seriousness is done by nurses and directs the demand to the most appropriate professional.[28]

Managers consider that social prescribing reduces the burden of pharmacological interventions.[29] Thus, yoga, mindfulness, art, and swimming classes may be the most appropriate benefits for some patients. However, some benefits may be very limited in rural areas where these alternatives do not exist.[30] Longitudinality promotes a stable and maintained relationship through time with the patient and has an important role in their experience.

Promoting it can be a challenge, since it is subject to the available human resources, especially during vacation periods or due to the rotation of professionals in the work center. To respond to this weak point, the Primary and Community Care Action Plan 2022-2023[31] proposes increasing the number of professionals to improve longitudinality.

The environment and work climate of professionals are essential to good patient care.[32] Despite the efforts of the managers to maintain a healthy work environment, the different developed actions have had little impact. Regarding this gold standard element, a difference in the worst-rated center managers' narratives is shown, who perceive negative dynamics of some patients toward professionals.

Although e-consultations can improve the patients' experience, some worst-score urban centers have limited e-consultation because they see patients as hyperdemanding. Those who had the best scores note that not all technologies are suitable for all patients. Due to the digital unfamiliarity, video consultations may not be suitable for older people.

Effective coordination between municipal and healthcare resources is complicated regarding integrated care. This difficulty causes activities to disperse and a lack of communication between both groups. Creating the Social and Health Care Agency (AGAISS)[33] can be an ideal resource for developing more integrated and personalized care.

An essential element highly valued by all interviewed managers is the health administrative team, which allows efficient agenda management and administrative tasks, relieving healthcare professionals of this work.

Managers focus more on the technical quality of the service and leave the quality of the service perceived by the patient in the background. On the other hand, some professionals believe that the association between service quality and patient experience needs to be sufficiently clear.

Limitations: The size of the sample is a possible limitation to generalization. An attempt has been made to minimize this limitation, as convenient sampling was conducted with a variety of participants. Another limitation is possible bias toward self-reported data by managers, as participants may have provided distorted responses to present a more favorable image of themselves. This bias has been reduced through data source triangulation: interviews and surveys.

Catalonia's geographical limitation may have limited the applicability of these findings in other regions. In future studies, incrementing sample size and including direct commentary from patients will help provide a more balanced and generalized vision.

Conclusion

The present study explores PCT managers' perceptions regarding the gold standard elements in Primary Health Care in Catalonia. Accessibility, nursing management, and administrative support are highlighted as essential aspects of the patient experience.

There are not any significant differences between best and worst-scored PCTs and the application of gold standard elements. In contrast to other studies,[34] our interviewees described better accessibility in rural PCTs. Likely, this is why rural centers with better temporal accessibility data are better valued by patients.

To respond patients' demands, professionals must be trained, motivated, and decisive in providing care; otherwise, they can generate an unfavorable patient experience and increase costs.

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Supplemental Material

Supplemental material for this article is available online.

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